Public Act 92-0579

HB5842 Enrolled

LRB9214435JSpc

AN ACT in relation to insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Section 370i and adding Section 356z.2 as follows:

(215 ILCS 5/356z.2 new)

Sec. 356z.2. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(215 ILCS 5/370i) (from Ch. 73, par. 982i)

Sec. 370i. Policies, agreements or arrangements with incentives or limits on reimbursement authorized.

(a) Policies, agreements or arrangements issued under this Article may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the insured.

(b) An insurer or administrator may:

(1) enter into agreements with certain providers of its choice relating to health care services which may be rendered to insureds or beneficiaries of the insurer or administrator, including agreements relating to the amounts to be charged the insureds or beneficiaries for services rendered;

(2) issue or administer programs, policies or subscriber contracts in this State that include incentives for the

insured or beneficiary to utilize the services of a provider which has entered into an agreement with the insurer or administrator pursuant to paragraph (1) above.

(c) After the effective date of this amendatory Act of the 92nd General Assembly, any insurer that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(Source: P.A. 84-618.)

Section 10. The Health Maintenance Organization Act is amended by changing Section 4.5-1 as follows:

(215 ILCS 125/4.5-1)

Sec. 4.5-1. Point-of-service health service contracts.

(a) A health maintenance organization that offers a point-of-service contract:

(1) must include as in-plan covered services all services required by law to be provided by a health maintenance organization;

(2) must provide incentives, which shall include financial incentives, for enrollees to use in-plan covered services;

(3) may not offer services out-of-plan without providing those services on an in-plan basis;

(4) may include annual out-of-pocket limits and lifetime maximum benefits allowances for out-of-plan services that are separate from any limits or allowances applied to in-plan services;

(5) may not consider emergency services, authorized referral services, or non-routine services obtained out of the service area to be point-of-service services; ~~and~~

(6) may treat as out-of-plan services those services that an enrollee obtains from a participating provider, but for which the proper authorization was not given by the health maintenance organization; and~~.~~

(7) after the effective date of this amendatory Act of the 92nd General Assembly, must include the following

disclosure on its point-of-service contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(b) A health maintenance organization offering a point-of-service contract is subject to all of the following limitations:

(1) The health maintenance organization may not expend in any calendar quarter more than 20% of its total expenditures for all its members for out-of-plan covered services.

(2) If the amount specified in item (1) of this subsection is exceeded by 2% in a quarter, the health maintenance organization must effect compliance with item (1) of this subsection by the end of the following quarter.

(3) If compliance with the amount specified in item (1) of this subsection is not demonstrated in the health maintenance organization's next quarterly report, the health maintenance organization may not offer the point-of-service contract to new groups or include the point-of-service option in the renewal of an existing group until compliance with the amount specified in item (1) of this subsection is demonstrated or until otherwise allowed by the Director.

(4) A health maintenance organization failing, without just cause, to comply with the provisions of this subsection shall be required, after notice and hearing, to pay a penalty of $250 for each day out of compliance, to be recovered by the Director. Any penalty recovered shall be paid into the General Revenue Fund. The Director may reduce the penalty if the health maintenance organization demonstrates to the Director that the imposition of the penalty would constitute a financial hardship to the health maintenance organization.

(c) A health maintenance organization that offers a point-of-service product must do all of the following:

(1) File a quarterly financial statement detailing compliance with the requirements of subsection (b).

(2) Track out-of-plan, point-of-service utilization separately from in-plan or non-point-of-service,

out-of-plan emergency care, referral care, and urgent care out of the service area utilization.

(3) Record out-of-plan utilization in a manner that will permit such utilization and cost reporting as the Director may, by rule, require.

(4) Demonstrate to the Director's satisfaction that the health maintenance organization has the fiscal, administrative, and marketing capacity to control its point-of-service enrollment, utilization, and costs so as not to jeopardize the financial security of the health maintenance organization.

(5) Maintain, in addition to any other deposit required under this Act, the deposit required by Section 2-6.

(6) Maintain cash and cash equivalents of sufficient amount to fully liquidate 10 days' average claim payments, subject to review by the Director.

(7) Maintain and file with the Director, reinsurance coverage protecting against catastrophic losses on out of network point-of-service services. Deductibles may not exceed $100,000 per covered life per year, and the portion of risk retained by the health maintenance organization once deductibles have been satisfied may not exceed 20%. Reinsurance must be placed with licensed authorized reinsurers qualified to do business in this State.

(d) A health maintenance organization may not issue a point-of-service contract until it has filed and had approved by the Director a plan to comply with the provisions of this Section. The compliance plan must, at a minimum, include provisions demonstrating that the health maintenance organization will do all of the following:

(1) Design the benefit levels and conditions of coverage for in-plan covered services and out-of-plan covered services as required by this Article.

(2) Provide or arrange for the provision of adequate systems to:

(A) process and pay claims for all out-of-plan covered services;

(B) meet the requirements for point-of-service contracts set forth in this Section and any additional requirements that may be set forth by the Director; and

(C) generate accurate data and financial and regulatory reports on a timely basis so that the Department of Insurance can evaluate the health maintenance organization's experience with the point-of-service contract and monitor compliance with point-of-service contract provisions.

(3) Comply with the requirements of subsections (b) and (c).

(Source: P.A. 92-135, eff. 1-1-02.)

Section 99. Effective date. This Act takes effect on January 1, 2003.

Passed in the General Assembly April 25, 2002.

Approved June 26, 2002.